THE COMMUNITY LEGAL CLINIC SYSTEM OF ONTARIO
QUALITY ASSURANCE PROGRAM
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1.0 INTRODUCTION

1.1 Purpose of the Document

This is an overview of the Quality Assurance (QA) Program for the Community Legal Clinic System of Ontario. The purpose of this document is to outline the components of the Quality Assurance Program.

1.2 Contents of the Document

The document contains five sections:

1.3 Background

The importance of accountability of publicly funded organizations and their role in protecting the public interest has been evolving in Ontario for the past decade. Every indication is that the trend will continue and probably at an accelerated pace as governments at many levels look for ways to trim spending yet increase service.

In 1992, the Operational Review of the Community Legal Clinic System conducted a survey and eighty-four percent of respondents from the Clinics indicated agreement that a system-wide Quality Assurance Program should be put in place in each Clinic. There was less agreement on just how such a process would work: some of the divergence around implementation was probably driven by unfamiliarity with quality assurance systems; some was probably driven by a concern over reviews being conducted by a central body.

The evaluation of public service organizations is in the midst of transition from checklist driven compliance reviews to ongoing quality management based systems. Several Ontario organizations that operate with public funds and in the public interest such as hospitals, insurance clinics, WCB funded community clinics and many of the regulated health professions are researching, developing and implementing accreditation systems that ensure continuing professional competency and that are at the forefront of human service management.

At the foundation of Quality Assurance programs is the notion that superior organizations which are operating in a quality fashion focus on several basic principles. One is understanding that the work produced by organizations is a function of a few interrelated key work processes. Five or six key work processes represent the activities that an organization would undertake to produce its output. By understanding the work processes and looking for opportunities to continually improve them, an organization can better fulfill its mandate. In this respect the work processes represent the dimensions of the quality of an organization.

A second principle of Quality Assurance programs is that improvements taken by an organization are usually continuous and incremental. The idea that fixing a few problems is an adequate way to improve quality originates from assembly line manufacturing where eliminating the bad product meant the product which was remaining was of better quality. In more complex service organizations the same approach is less successful. Therefore, isolating opportunities for improvement, understanding their cause and then making amendments to improve the process producing those causes, will ensure that a service organization is improving quality. The notion that the improvements should be continuous suggests that the need for improvement itself is always changing, and in service organizations that are serving the needs of people this is a reasonable assumption.

A third principle of Quality Assurance programs is that the general yardstick for improving work processes is customer expectations. Successful organizations listen, calibrate and respond to the needs of a variety of internal and external customers. This often requires a regular program of individual client customer surveys and periodic contact with major external customer organizations to review the perceptions of how an organization is meeting expectations.

Another principle of those QA Programs which focus on quality management is that there is a need for statistical and evidence-based description of variations in work process and other components such as customer expectations. Throughout the development of a successful Quality Assurance Program statistical data should be kept, monitored and understood at all levels of an organization.

While there are a few other principles that guide this type of Quality Assurance program, the final major one mentioned here is that service organizations can benefit from the experience of the experts working in the system. When opportunities for improvement are identified, it is often best to use expertise existing in the system to define the opportunity for improvement, understand the possible causes for such a situation and generate innovative ways of resolving and improving circumstances. This requires facilitative and team leadership skills on behalf of management.

These major principles have helped frame the development of the Quality Assurance Program for the Community Legal Clinic System and will direct its further refinement and implementation in all aspects.

1.4 Next Steps

Work will proceed in developing the detailed support documents that are called for throughout this Program outline. The documentation will include:

- Draft of advance preparation material for use by Clinics
- Draft of site visit survey tool including quality criteria, indicators and areas of interviewing
- Guidelines for Becoming Peer Mentors
- Detailed Quality Assurance Indicators

These detailed documents will be completed in September, 1996, and distributed to staff in the Community Legal Clinic System, in early October, for information and comments on completeness and accuracy. The Quality Assurance Program will be included on the agenda for the Fall management training conference with Clinic Executive Directors on October 23rd or 24th. Implementation of the Quality Assurance Program will be in late 1996 or early 1997.

2.0 OBJECTIVES AND PRINCIPLES

This Quality Assurance Program is developed so it will achieve a fundamental objective -

To allow for an ongoing, verifiable assessment of the quality of the operation of Community Legal Clinics.

In order to achieve this objective, the following principles are considered important to the development and implementation of such a Quality Assurance Program:

- Quality Assurance will focus on the operations of Clinics including the quality of legal file management
- the Quality Assurance Program is meant to be supportive and facilitating
- the Quality Assurance Program staff will not make funding decisions
- the Quality Assurance Program builds upon current structures and information available in the Clinic System
- the Quality Assurance Program will be adequately resourced.

3.0 ORGANIZATION OF QUALITY ASSURANCE PROGRAM

3.1 Overall Responsibility

The Quality Assurance Program Director will report to the Funding Manager .

The Program has been designed to be as separate as possible from funding decisions while still maintaining the system-wide benefits of central coordination: program consistency, economies of scale in developing new approaches and ideas, and the ability to account publicly for the whole system.

Specifically the following structure is recommended:

3.2 Separate Quality Assurance Program Staff

Quality Assurance Program reviewers must have lengthy experience working in the Clinic system. A reviewer must be a lawyer with experience working at the Executive Director or similar level. The Director will report to the Clinic Funding Manager, but it is important that the individual be viewed as separate from normal Clinic funding office operations. Therefore, it is preferable that the Quality Assurance Program Director benefit from the direction and policy advice of a Quality Assurance Steering Committee that would be comprised of members of the Clinic system similar to the CRO Steering Committee.

3.2.1 Position Description for QA Program Director

The Quality Assurance Program office will operate separately from the day to day activity of the Clinic Funding staff. The person in charge of the Quality Assurance Program should operate similarly to an Executive Director of a Clinic. The Quality Assurance Program Director would be responsible for the development, implementation and maintenance of the Quality Assurance Program including:

- completion and implementation of an education and communication plan for the implementation of the Quality Assurance Program, including using volunteers and other strategies aimed at facilitating effective implementation

- development, testing and refinement of a process for implementing the Quality Assurance Program

- based upon the early operation of the Quality Assurance Program, development of a set of quality service best practices (benchmarks) for the Clinics

- development and maintenance of a database of information on Clinics

- preparation of system-wide reports

- development and maintenance of a peer mentor network and training peer mentors

- development of support materials for Clinics with problems

- participation in Clinic system training events

- working with Clinics, as appropriate, with implementation of the Program at an individual Clinic level

- development and implementation of system-wide quality indicators and reporting from time to time to the Clinic Funding Manager

- operating as a Quality Assurance Program reviewer and conducting site visits.

3.2.2 QA Program Positioning

To accentuate the nature of the Quality Assurance Program as being supportive, facilitative and as separate as possible from Clinic Funding Staff, the reports prepared by the QA reviewer will be restricted to comments on the Clinics' ability to respond to the standards and processes outlined within the Program. Funding decisions will continue to rest with Clinic Funding Staff. (cf.: Reports in Section 4.5.1.) As outlined below, copies of QA reports will go to the Clinic Funding Manager. They may, therefore, influence funding decisions. However, the role of the QA staff will be to assess clinics, not to decide any funding consequences.

To enhance this separation, the Quality Assurance staff should be in a location other than the Clinic Funding Office, perhaps at the CRO.

3.3 Clinic Responsibility

The standard Clinic certificate will be revised to require that:

- Clinics cooperate in the Quality Assurance Program
- Executive Directors of all Clinics be responsible for the preparation, implementation and follow-up required with the Quality Assurance Program as part of their position
- all client retainers, from the time of the revised certificate, must be revised to allow review of client files by QA Program reviewers.

4.0 OPERATION OF THE QUALITY ASSURANCE PROGRAM

4.1 General Program Overview

The Quality Assurance Program will expect each Clinic to review and document its conformance to and ability to achieve certain standards of Clinic operation. Each Clinic will do a certain amount of preparation for its Quality Assurance review. Each Clinic will be visited by the Quality Assurance Program reviewer to go over the Clinic's ability to achieve Program standards. The reviewer will prepare a report on the visit and recommend, if needed, certain follow-up be undertaken by the Clinic management. The report will be addressed to both the Board and Executive Director of the Clinic and, in some cases, a copy will go to the Clinic Funding Manager (c.f. 4.5.1). In certain circumstances, more detailed peer mentoring may be requested by the Clinic or the Program reviewer.

4.2 Work Processes Of The Quality Assurance Program

The Quality Assurance Program can be characterized by five major work processes. Theyare:

- Program Management
- Communication and Education
- Reporting and Benchmarking
- Site Visits
- Facilitating Improvements

What follows is an overview of the steps involved in each of these processes. At this point in the Program development, these activities should be viewed as directional and not definitive. Within the next few months and before implementation of the Program, these activities will be refined and developed with particular attention to the guiding principles that call for avoiding work duplication, offering a facilitative

Quality Assurance environment and providing a definitive assessment of Clinic and system accountability.

4.3 Program Management

The components involved with this work process are outlined in the position description for the QA Program Director in Part 3.2.1.

4.4 *Communication and Education*

The process steps involved with Communication and Education include:

4.4.1 QA Program Implementation

The initial communication education objective for the Director of the Quality Assurance Program is the successful launch of the Program itself. It is proposed that implementation would occur in phases, and each phase would allow for a high degree of education and development of Clinic staff.

4.4.1.a. Timing -First Three Months

In the first three months of the Program, some details of the Program will be finalized, Clinics will receive implementation information and volunteer Clinics for early visits will be recruited. A few peers will also be selected and trained.

It is hoped that six Clinics will volunteer to be involved with this first phase. A meeting will be convened among the six Clinics by the Program Director in order to review the proposed process outlined in this document. The Clinics will be given an opportunity to fine tune any areas of concern. The six Clinics will then receive correspondence and will be visited as outlined in the Site Visit work process. A major difference for this introductory stage will be the time that it will take for each one

of the steps. In general the QA Program Director will take twice as long to go through the six initial site visits as would be anticipated once the program is operating at a steady state.

4.4.1.b. Timing -Months Four and Five

For months four and five, Clinics will be visited at a rate of one per week. This will allow for any operational bugs to be identified and improved.

It is intended that a further ten Clinics would volunteer for this intermediate stage. With benefit from the development of the current document and the initial six Clinic launch, the Director will implement the Site Visit process in final form. This series of ten visits over two months will allow the Program Director to fine tune the operation of internal office sub processes such as note taking, sending out letters of notice, travel, and report writing.

4.4.1.c. Timing -Months Six to Twenty-Four

Full implementation of the Program will occur from month six onward, and every Clinic will be visited by the end of the second year of operation.

4.4.2. Education

From time to time the QA Program Director will want to ensure that certain educational activities are carried out. This could take the form of a regular quarterly newsletter, an annual report to the system or special educational topics that may relate to aspects of the QA Program.

4.5 *Reporting and Benchmarking*

The process steps involved for Reporting and Benchmarking would include:

4.5.1 Quality Assurance Reports - Clinic Level

Based upon a Clinic's operation, the reviewer will write a report to the Board and Executive Director of the Clinic. In that report the Clinic will be evaluated as to its ability and potential in attaining the quality standards. Each Clinic will be evaluated as holding one of three positions on a quality assurance continuum, as listed below. The expected standard intervals for visiting and reporting are noted, but these remain at the discretion of the Director and may vary for individual Clinics.

A summary of the QA Program reporting structure is attached to this document.

Position 1

Clinic is achieving all or nearly all of the quality assurance standards. Any quality improvements that are required are acknowledged by the Clinic which along with the reviewer agrees improvements can be attained within three months. The next full quality assurance review will be in two years. Improvements required are not serious enough to warrant any further action before the next full review.

The Clinic's Board of Directors will receive a copy of the QA Program report. The Clinic Funding Manager will receive a statement that the Clinic has been classified as Position 1 and that the next full quality assurance review will be in two years.

Position 2

Opportunities for improvement are more evident as the Clinic is achieving most of the quality assurance standards but some important areas have not received adequate attention. The reviewer believes that improvements can be attained within six months. A peer mentor for advice on some of the major processes may be recommended by the reviewer. A follow-up visit will occur in six months. If the improvements have not been achieved by that time, there will be subsequent follow-up visits as required until the Clinic does reach Position 1 status. The next full quality assurance review will be two years after the initial visit.

After the initial visit, the Board of Directors will receive a copy of the QA Program report. The Clinic Funding Manager will receive a statement showing that the Clinic has been classified as Position 2. After the six month follow-up visit, if the Clinic has reached Position 1 status, the Clinic Funding Manager will receive notification that the Clinic is now classified as Position 1. If the necessary improvements have not been made by the six month visit, then the Clinic Funding Manager will receive a copy of the QA Program report. There will then be follow-up status reports by the QA Program reviewer at three month intervals, copied to both the Board of Directors and the Clinic Funding Manager .

Position 3

There is, in the eyes of the reviewer, substantial effort required before the Clinic is able to respond to the Quality Assurance Program in a way that serves its community's needs. Most of the quality assurance standards are not being met. A report outlining opportunities and mechanisms for improvement will be prepared. It is likely that a visit from a peer mentor will be required by the reviewer. Follow-up visits will be frequent with a view to facilitating the Clinic's efforts at undertaking the Program improvements. A written reassessment of the

Clinic will be made at three month intervals until Position 1 status is achieved.

The Board of Directors and the Clinic Funding Manager will receive a copy of the QA Program report after the initial visit. There will be follow-up status reports by the QA Program reviewer at three month intervals, copied to both the Board of Directors and the Clinic Funding Manager .

4.5.2. Quality Assurance Reports -System Level

From time to time as requested by CFC, and at least annually, the Director will prepare a report on the quality management of the Community Legal Clinic System as a whole. The report will, in a manner that respects individual Clinic confidentially, highlight the strengths of the system, outline major accomplishments in terms of quality assurance and provide an assessment of the overall accountability of the system.

4.5.3. Quality Assurance Reports – Benchmarking

On a periodic basis the Director of the Quality Assurance Program will take a cross-sectional analysis of a particular work process and analyze how it is being carried out in a range of Clinics. For example, in the reviews of legal file management that have been reported for 12 or 15 Clinics, the Director will analyze the range of work that is being carried out in those Clinics with a view to isolating some "best practice" behaviours. The analysis would go on to recommend a benchmark or expected approach to dealing with legal file management. These reviews would protect individual and Clinic confidentiality. The benchmark recommendations would be reviewed with the Steering Committee and, when endorsed, would be communicated to the wider Clinic system. If appropriate, the standards outlined within the QA Program and the questionnaire would be appropriately amended to reflect the continuous improvements brought on by cross-sectional

analysis. This ongoing review of the standards and communication of benchmarks, would see approximately four analyses carried out each calendar year .

4.6 *Site Visits*

The process steps involved for Site Visits would include:

4.6.1. Visit Preparation

4.6.1.a. Annually the QA Program Director will prepare a list of Clinics that would be visited within that year. This list would be distributed to Clinics and the Clinic Funding Manager and not subject to revision except in extraordinary circumstances.

4.6.1.b. The list would be prepared and distributed at least three months before the end of the calendar year ensuring that no Clinic has fewer than three months notice of a potential visit.

4.6.1.c. After the publication of the list, the QA Program Director will send a letter addressed to the Board and Executive Director of each Clinic on the list indicating that it is scheduled for a visit within the next three to twelve months. A preparation guide for the Clinic will accompany the letter. The preparation guide will contain an overview of the site visit process, a suggested schedule for a site visit day, a self-study questionnaire and a request that the Clinic respond with any dates that would be completely impossible for a site visit during the indicated time frame.

Three Months Prior To Clinic Visit

4.6.1.d. The QA Program Director will send a letter to both the Board and Executive Director of the Clinic indicating the dates that have been scheduled for a Clinic visit. This will request that

interview times be arranged for a variety of individuals and that a schedule be set up for the visit including staff and other interviews. The Clinic will be requested to confirm that the dates are suitable and that the interview schedules will be established. (See Pro Forma list of interviews and meeting schedule in point 4.6.2.a below.)

Two Months Prior To Site Visit

4.6.1.e. The QA Program Director will send a letter to the Clinic to ensure that the Quality Assurance questionnaire has been completed and that a copy is forwarded to the reviewer. This letter will also ask that certain materials be compiled by the Clinic for review by the reviewer during the site visit. These materials would be existing Clinic materials that will need to be pulled together in one location in order to avoid searching out documents during the day of the site visit. Such documentation would include copies of Board minutes, staff minutes, the Strategic Plan, newsletters, customer service surveys and the like. The full list will be determined by the system-wide quality standards.

One Month Prior To Site Visit

4.6.1.f. The QA Program reviewer should request and receive a final copy of the interview schedule and confirmation that all the materials have been compiled as requested.

4.6.1.g. The QA Program reviewer will extract from the most recent Clinic funding application and other centrally produced data, certain statistics that describe the operation of the Clinic. This is to ensure that the Clinic is not requested to duplicate information it has already provided to Clinic Funding.

Two Weeks Prior To Site Visit

4.6.1.h. The QA Program reviewer will spend approximately one half of a day to one day reviewing all of the information on hand including the completed questionnaire and the statistics compiled from the funding application. This preparation will raise some questions that should be focused upon during the actual site visit. The reviewer's observations and questions should be documented on the file. The reviewer should also telephone the Clinic on its public line to check on telephone accessibility.

4.6.2. Site Visit

A site visit will normally take two days. The times below indicate approximate time for a Clinic visit.

4.6.2.a. Each site visit will include the following components:

- introductory interview with Executive Director to review existing materials and to raise any questions that may have surfaced during the reviewer preparation of material. Brief tour of Clinic. Discussion of intake system and file management policies/procedures. (approximately 2 hours)

- interview with Board Chair and at least one other Board member (20 minutes each)

- interview with (at least) one staff lawyer, one CLW and one support staff (15 to 30 minutes each)

- interview with customers including a client, external agency and member of local bar (10 minutes each)

- lunch break and analysis and review of information to date (2 hours)
- follow-up meeting with Executive Director and other staff to verify responses in survey / questionnaire (1 hour)
- review of a sampling of client files (4 hours) (1 hour per case worker)
- interview with Executive Director (30 minutes)
- review sampling of summary intakes (45 minutes)
- observe operation of intake system (30 minutes)
- review use of technology (30 minutes)
- review of law reform and community development work (1 hour)
- concluding meeting with ED (1 hour)

At this time, the review of client files is not intended to evaluate the quality of legal work performed or second guess the professional judgment of caseworkers. Instead, client file reviews will focus on the following:

- file management: is the file organized? can another lawyer pick it up and understand it? is there adequate docketing? are retainers completed? are file notes properly kept? documents organized? *etc.*
- limitation periods
- supervision and case consultation

- case management: if the Clinic has case management procedures for certain types of files, are they carried out in practice?

- are files dealt with in a timely manner?

- is there adequate communication with the client? are there opening and closing letters?

- egregious legal errors: while the goal is not to review judgment calls by caseworkers, reviewers will make note of legal advice which is simply wrong.

The Day Following Site Visit

4.6.2.b. Each Clinic visit should be well documented with notes to file the day following the site visit, and any information requested during the visit that was not available at that time should be requested in writing.

Within Two Weeks Of Site Visit

4.6.2.c. Finalization of the QA report for the subject Clinic

4.7 *Facilitating Improvements*

The process steps involved for Facilitating Improvements include four sub processes, specifically: assistance from QA Program, peer mentoring, follow-up site visits and special referrals. The steps involved in these sub processes include:

4.7.1 Assistance From QA Program

Depending on the circumstances and resources available, the Quality Assurance Program may provide assistance with required

improvements. The Program is expected to develop materials designed to assist Clinics with improvements in various areas. Having decided that a Clinic is not meeting required standards, a Quality Assurance reviewer may provide suggestions on how best to meet those standards and provide materials and/or advice to assist in the process of improvement.

4.7.2. Peer Mentoring

4.7.2.a. Overview

Peer Mentoring refers to a site visit to a Clinic by a selected and trained peer, usually an Executive Director of another community Clinic. The visit will usually entail interviews and review of Clinic material, including Clinic operations and file management, for the purposes of helping the Clinic devise and implement a program of improvements to one or more of its major work processes. A peer mentoring intervention can be required or suggested by the reviewer or can be requested by the Clinic. The peer mentor will have training and facilitating materials to assist in the conduct of the visit. The peer mentor will be in communication with the Program reviewer while working with the Clinic. Reports prepared by the peer mentor will be addressed to the Clinic and available for review by the Program reviewer.

4.7.2.b. Peer Selection

Peer mentors must be experienced Executive Director/lawyers or have equivalent experience. Those interested will be required to outline their experience in the Clinic System as well as their availability and willingness to take training. The Director, with consultation, will select and qualify those able to

undertake peer mentoring. At any given time there will be approximately 10 individuals. Qualification will be subject to annual review by the Director with comments from those Clinics and staffs mentored. There will normally be a five year term limit.

4.7.2.c. Peer Assignment

When it is deemed preferable to use the option of peer mentoring, both the Quality Assurance Program Director and the Clinic in question should be involved in the decision on which peer is engaged. It is suggested that explicit criteria for appointments be developed including an inventory of particular management strengths of the qualified peers, interests of qualified peers, geography and peer mentoring experience. From a list prepared by the Director of five or six potentially suitable candidates, the Clinic will be asked to short list three or so individuals from which the Director will try to select one based on availability .

4.7.2.d. The Role of Peer Mentoring

The engagement of a peer mentor is not another layer of investigation into things that are not working right at a particular Clinic. The idea of using a peer mentor is to assist Clinics, particularly Executive Directors, to devise programs for improvement. Their interventions should be viewed as constructive, confidential and building upon the comments offered by the reviewer during the first visit.

4.7.3. Follow-up Site Visits

As has been outlined in the report section, for Position 2 and Position 3 Clinics the QA Program reviewer may require follow-up site visits in order to see the degree to which improvements have been occurring.

These visits would be to review the opportunities for improvement outlined in the report following the first visit. The intent of follow-up site visits is not that the reviewer become involved in the day to day management or improvement process at the Clinic. The follow-up visits will be designed to facilitate improvements by the Clinics themselves. It is suggested that a Position 2 Clinic would require one or two follow-up visits on average. A Clinic evaluated at Position 3 would probably require several follow-up visits.

4.7.4. Special Referrals

Depending on the circumstances at a particular Clinic, the reviewer may want to arrange for special referrals. For example, a Clinic that is observed to have chronic human resource record keeping problems that do not seem to be resolvable during the normal course of business, may be referred to a special human resources consultant. Similarly consultants in some other areas of communication or legal file management may also be referred. It would be the responsibility of the QA Program Director to develop and maintain a list of effective referrals for such alternatives.

Periodically, it is possible that the special referrals portion of this key work process may require the QA Program Director to organize a special workshop. If a problem is systemic and viewed as a barrier to improving quality management, the QA Program Director will organize a workshop as part of the management training conference or other special event (c.f. 4.4.2 Education).

5.0 QUALITY STANDARDS

In February 1987, the Clinic Funding Committee adopted a policy setting out Clinic Performance Evaluation Criteria. This summarized several years of consultation around issues of performance evaluation in the clinics. At that time the criteria outlined carried general support from the system as being comprehensive, fair and with a good deal of rigour to allow for reasonably objective assessment of clinic and system behaviour. The criteria were developed in consultation with clinic representatives and were approved by the Ontario Association of Legal Clinics. They were distributed in a binder entitled *Materials for the Clinic Performance Evaluation Criteria* in July 1988. Every clinic should have a copy of this binder in their library.

This document uses the material outlined in that 1988 report as a starting point and builds upon it with material designed by others for a similar purpose. In this regard the work done by Legal Services Corporation in the U .S. as well as found in a wide range of other Ontario human service organizations has been particularly helpful in confirming and, in a few spots, revising the thirty-two evaluation criteria outlined in the 1988 material. These materials from other organizations have been helpful in early development of the Indicators that Criteria are being met.

5.1 Service Dimensions

For the purposes of this Quality Assurance Program there are five major work processes. They are:

1. Board Governance And Overall Management
2. Understanding The Community
3. Program Planning, Development And Evaluation

4. Communications -Internal and External
5. Services: Legal File Management
   Summary Advice Law Reform
   Community Development
   Community Legal Education.

5.2 Criteria and Indicators

A Quality Assurance Criterion is a standard that should be met in order to ensure the work process is being satisfactorily accomplished. A Quality Assurance Indicator provides for a way to measure whether the Criteria are in place.

In the following charts each work process has assigned to it those appropriate Criteria from the *Clinic Performance Evaluation* document. Following each is the reference number from the original document. One of the criterion was edited from the original and it is marked with [ed], and one criterion appears twice and it is marked with [rep]. In addition a few criteria have been added and marked with [add]. Their inclusion comes from a review of similar material used by LSC, ABA and other Ontario based organizations undertaking similar processes.

The Indicators column at this time contains examples for illustrative purposes only. This is because the focus of the current document is to outline the direction of the overall Program and of the broad areas that define quality. The detail around the indicators will be completed as part of the next steps during September, 1996.

SUMMARY OF QUALITY ASSURANCE PROGRAM REPORTS

Position 1

- Clinic achieving all or nearly all quality assurance standards
- Required quality improvements are acknowledged by the Clinic
- QA Program sends full report to Clinic Board of Directors and confirmation of Position 1 status to CFM

Position 2

- Clinic achieving most quality assurance standards but important areas have not received adequate attention
- Peer mentor may be recommended
- QA Program sends full report to Clinic Board of Directors and confirmation of Position 2 status to CFM
- Follow-up review in six months:

a. if all quality improvements are attained, QA Program confirms change to Position 1 status to CFM and sends written report to Board of Directors;

b. if improvements are still required, follow-up review at 3-month intervals, QA Program confirms no change in Position 2 status and sends full reports to CFM and to Board of Directors

Position 3

- Clinic not achieving most quality assurance standards
- Peer mentor may be recommended
- QA Program confirms Position 3 status to CFM and sends full report to CFM and Board of Directors
- Follow-up review at 3-month intervals
- QA Program confirms change or no change in Position status to CFM and sends follow-up status report to CFM and Board of Directors at 3-month intervals

QUALITY DIMENSION (Work Processes	CRITERIA (Standards)	INDICATORS (Measurements) (Only a few examples shown at this time)
	Governance	
1. Board Governance and Overall Management	1.1 Composition of the Board of Directors reflects a balance of low-income representatives, independent legal skills, financial skills, and experience working in community based groups. [3]	Review of Board membership. Recruitment/ cultivation processes.
	1.2 The Board of Directors is independent of other community groups and of its staff. [4]	Board appointments.
	1.3 The Board of Directors acts as a policy board, and does not try to manage the day to day activities of the clinic. [Sed]	Review of minutes and reports.
	1.4 The Board of Directors of the clinic sets priorities for client services within the overall clinic mandate, which recognize the highest needs for legal services in the low income community served by the clinic. [11]	Documented plans.
	1.5 Orientation and training of new Board members is carried out. [23]	Review of orientation process and materials.
	1.6 The Board of Directors regularly review clinic activities in casework, law reform, community organizing, and public legal education and reviews short and long term plans to achieve clinic objectives. The Board of Directors will have in place management systems such as information systems, a staff evaluation procedure and Board management systems and structure. [24]	Minutes. Performance evaluation system. Organization charts.

Government and Management continued...	1.7 The clinic is able to attract and keep members of the Board of Directors. [28]	Analysis of Board turnover.
	1.8 The Board of Directors makes use of its Executive Committee structure to allow productive use of meeting time. [29]	Minutes.
	1.9 Cooperative Board/Executive Director relationship. [add]	
	Overall Management	
	1.10 Financial procedures, financial controls, and reporting procedures are sound. [6]	Audited statements. Budget process and Results.
	1.11 The intake system, case assignment system, the assignment of other clinic work, and the overall organization of staff make efficient use of staff time and abilities. [7 rep]	Review of procedures. Review of case docketing. Review of personnel policies, procedures and administration
	1.12 Initial and ongoing staff training is adequate and appropriate. [13]	Training agenda.
	1.13 The job descriptions and staffing ratios adopted by the Board of Directors are designed to meet the staffing needs of the clinic operations. [17]	Review documents.
	1.14 The clinic utilizes its physical facilities efficiently, including satellite offices, hours of operation and access by the public, use of equipment, use of space and initiatives to control costs. [18]	Site inspection.
	1.15 Effective use of technology to provide services efficiently. [add]	Customer satisfaction survey.

2. Understanding The Community	2.1 The Board of Directors has documented the need for legal services for low income people in the community served by the clinic, particularly taking into account circumstances in the local community and other services available to low income people. [9]	Review of documents and sources.
	2.2 The clinic has a method of gathering information regarding current trends and changing cultural/ economic patterns in the community , for use in planning. [10]	Review of documents and sources.
	2.3 The clinic regularly receives and evaluates input from its many customer groups including the community , clients, the legal profession. [add]	Customer satisfaction surveys. Interviews.

3. Program Planning, Development And Evaluation	3.1 The clinic provides a range of client services, as described in the Regulation on clinic funding. [1]	Review of activity. Funding application.
	3.2 The clinic has in place a system of annual planning and evaluation. [8]	Documentation.
	3.3 The clinic articulates clear measurable objectives for client services based on the priorities of the Board of Directors, and assigns activities to achieve each objective. [12]	Documentation.
	3.4. That the general clinic takes into account the services and expertise provided by specialty clinics when planning the clinic's priorities.	Policies.
	3.5 The clinic is responding to current trends and changing cultural/ economic patterns which affect the legal needs of low income people in the community serviced by the clinic by regularly reviewing local economic and demographic factors and appropriately updating or revising priorities for clinic services, as is necessary .[15]	Documentation.
	3.6 Activities in all areas of client services, including casework, public legal education, law reform, and community organizing are integrated to reflect the priorities established by the Board of Directors and to achieve maximum impact of the clinic services in those areas of priority. [16]	Program review. Activity review from funding application.
	3.7 The specialty clinic acts as a resource to general clinics by provision of expert advice and assistance, and in interclinic training. [31]	Referrals.

4. Communications -Internal and External	4.1 The clinic's complaint procedures allow for the unobstructed expression and resolution of complaints about any aspect of the clinic. [25]	Review of sample of complaint files. Customer satisfaction survey.
	4.2 The Board of Directors has developed a process for making the public and other Staff has regular contact with community agencies aware of clinic services; i.e. the clinic groups. has a stable or expanding membership base: or the clinic can demonstrate community support by attendance at general meetings or other evidence. [26]	Documented communications plan. Staff has regular contact with community groups.
	4.3 The Board reviews the level of community awareness and support for the clinic from time to time. [27]	Customer satisfaction survey. Communications plan.
	4.4 The clinic maintains high level of internal staff and staff-management-board communications and staff morale is maintained. [add]	Minutes of meetings. Newsletters. Interviews.
	4.5 The clinic is involved with inter-clinic organizations.	Interviews.

5. Provision of Services	5.1 The clinic provides legal intervention, advocacy, and litigation at many levels of the administrative / judicial decision-making process. [2]	Activity review. All clients meet system criteria.
	5.2 Services are provided in a manner which Customer surveys. is respectful of clients and designed to deliver Interviews. quality services in a timely manner. [add]	Customer Surveys. Interviews.
	5.3 The intake system, case assignment system, the assignment of other clinic work, and the overall organization of staff make efficient use of staff time and abilities. [7 rep]	Staff interviews. Caseloads. Client interviews. Docketing review.
	5.4 Supervision procedures are appropriate for the needs of the clinic and are applied to all legal services provided. [19]	File review of case file maintenance. Interviews.
	5.5 The tickler system meets with the standards required by the Law Society of Upper Canada, and is appropriate to the particular needs of the clinic. [20]	File review of case file maintenance.
	5.6 Client confidentiality is respected during intake procedures, file management procedures, and telephone and personal interview procedures. [21]	Review of processes. Language capabilities. Security /privacy arrangements. Orientation and training.
	5.7 The general clinics use the services and expertise provided by specialty clinics. [23]	Referrals.
	5.8 The specialty clinic has developed an Review of strategic plan. advanced understanding of the issues of law Activity review from funding application. relevant to its areas of specialty and a level of Interviews. expertise beyond that which may be possible in general clinics. [30]	Review of strategic plan. Activity review from funding application. Interviews.

Provision of Services continued...	5.9 Clinic is accessible for clients, by telephone and in person, and is accessible for handicapped clients	Interviews. Site review
	5.10 The specialty clinic engages in more sophisticated legal services as defined by the Regulation within its area of specialty than may be possible in the general clinic. [31]	Activity review from funding application. File review.
	5.11 Law reform activities are carried out at an appropriate level and in an effective manner. [add]	Docketing review.
	5.12 Community development is carried out at an appropriate level and in an effective manner. [add]	Activity reviews. Interviews.
	5.13 Community legal education is carried out at an appropriate level and in an effective manner. [add]	Activity reviews. Interviews.